STATEM	FERS FOR MEDICAR ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	
		09G072	B. WINC			
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		<u>19/2010</u>
RCM	OF WASHINGTON			1318 45TH PLACE, NE WASHINGTON, DC 20019	-	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR		
TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOLLIDE	COMPLE DATE
W 00	O INITIAL COMMEN	πs	W 00		. , , , , , , , , , , , , , , , , , , ,	
	A recertification su	rvey was conducted from		1, 19-2010		
	survey was initiated	rough March 19, 2010. The		4-19-2010 Received		
	Process. A rangon	n sample of three clients was pulation of four female and two	,	OVERNMENT OF THE DISTRICT OF C	COLUMNIA	
	ingle clients with A	MOUS levels of mental	Ċ	DEPARTMENT OF REALTH		
	retardation and dis	abilities.		HEALTH REGULATION ADMINISTS 825 NORTH CAPITOL ST., N.E., 2ND		
	The findings of the	survey was based on	i	WASHINGTON, D.C. 20002	LOOM	
	observations at the	group home and two day				
	clinical and administincident reports.	s with staff, and the review of strative records including				
N 120	483.410(d)(3) SER	VICES PROVIDED WITH	W 120			
	OUTSIDE SOURCE	ES		The facility nurse reported to c		
	The facility must as	sure that outside services		program, and inserviced the st		
	meet the needs of e	each client.		#1's mealtime adaptive equiprimealtime protocol.	nent, and	3-19-1
	<u>.</u>	ļ		The day program was provided	d with all	2-13-1
	This STANDARD is	not met as evidenced by:		of client #1,s mealtime adaptive		t.
	review, the facility fa	on, staff interview and record illed to ensure outside		The facility nurse went to inser-	vice the	
	services met the clie	ents needs, of one client		day program staff again on		4-15-1
i	included in the samp	Die. (Client #1)	ļ	Refer to attachment #1.		
	The findings include	:				
ļ	I. The facility failed to	o ensure that staff working	.	In the future, the facility manag		
	with Chent #1 at her	day program were using the	ļ	ensure that client #1 uses simi		
!	recommended adapt	tive feeding equipment.		adaptive equipment at the faci at the day program; in addition	•	5
!	During mealtime obs	ervations on March 17,		is visiting the day program on a		s
:	2010, at 7:30 a.m., 4	:00 p.m., and 7 10 p.m. staff		during lunch time to ensure that	at client #1	
	Client #1's spoon and	spoonfuls of food on the handing it to the client. The		is provided with the appropriat	te mealtime	
:	cient was observed i	Putting the food into her used a		adaptive equipment		
ATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	JR a	TITLE	Ott	B) DATE
<u> IVV</u>	ALL FAMILIA	Lia 1820 Of 101 M	1/10	n may be excused from correcting provid	11 0	à.

DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HDWV11

is also wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 as following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

Facility ID: 09G072

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES			PRINTE	D: 04/08/2 010
_CENTER	S FOR MEDICARE	& MEDICAID SERVICES			FORI	M APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LTIPLE CONSTRUCTION (X3) DATE	SURVEY
		09G072	The facility nurse reported to client #1's day program, and inserviced the staff on client #1's mealtime protocol. The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtime ensure that client #1 uses similar mealtime			
NAME OF PE	OVIDER OR SUPPLIER			Т.		19/2010
	WASHINGTON				1318 45TH PLACE, NE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(XS) COMPLETION DATE
W 120	Continued From page	ne 1	104	40		
i 1	right handled curved	d spoon, high side plate, ey cup, to assist with her	; w · 	12		
PO Rannes remains line in covering the covering state of the cover	day program on Mai The day program sta- client, using hand over elevated plate riser, and spoon and a sta- during the meal. The during the meal. The during the meal of the the elevated plate and that the dispersed items during the cord review on Mai proximately 5:17 putritional assessment ecommended a right ded plate, and dyce eview on the same of the tribulational quarter ecommended that a dinimize spillage during the ecommended that a dinimize spillage during the second and and verbally cue the tribulational (QMRP) opproximately 11:00 a dicated that the day	e.m., revealed that Client #1's nt dated October 12, 2009, thandled curved spoon, high mat. Additional record date and time revealed Client erly dated January 2, 2010, "nosey cup" be used to ing the meal. The tated, "she is an with staff supervision." Staff of front of the her and by putting the spoon in her			program, and inserviced the staff on client #1's mealtime adaptive equipment, and mealtime protocol. The day program was provided with all of client #1,s mealtime adaptive equipment. The facility nurse went to inservice the day program staff again on Refer to attachment #1. In the future, the facility management will ensure that client #1 uses similar mealtim adaptive equipment at the facility as well at the day program; in addition, the QIDP	3-19-10 nt. 4-15-10 e as

DEPAR CENTE	RTMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 04/08/2010 A APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TPLE CONSTRUCTION	(X3) DATE S	
	A	09G072	B. WI	NG_			
NAME OF	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/	19/2010
RCMO	F WASHINGTON			1	1318 45TH PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRICED TO THE APPROPRI	IIDRE	(X5) COMPLETION DATE
	revealed that he ser assessment to the dispersion and any program of the day program on March observations and program on March day program on the elevated plate interview with the day 2010, at approximate client #1 required harmather meals. Record review on March day 5:17 p. nutritional assessment of the meal in front of the client with staff support the meal in front of the client of the hard and verbanterview with the QMI interview with the QMI	pensed practical nurse on approximately 1:00 p.m., at a copy of the nutritional lay program nurse in January cation on March 19, 2010, at com., revealed documentation in nurse that they received I assessment and feeding to ensure that staff working day program provided the assistance during her meal. Were observed at Client #1's ch 17, 2010, at 12:50 p.m. at regular plate, a built up styrofoam cup were used a plate was observed sliding riser. Program staff on March 17, ly 1:20 p.m., revealed that and over hand assistance to rch 17, 2010, at m., revealed Client #1's t dated October 12, 2009, at was an independent ervision. The staff should for the [the client] and to eat, by putting the spoon lly cueing [the client] to eat. RP on March 19, 2010, at	W	120	The facility nurse reported to cliprogram, and inserviced the start's mealtime adaptive equipmental mealtime protocol. The day program was provided of client #1,s mealtime adaptive. The facility nurse went to inservice day program staff again on the future, the facility manage ensure that client #1 uses similial adaptive equipment at the faciliat the day program; in addition, is visiting the day program on an aduring lunch time to ensure that is provided with the appropriate adaptive equipment	off on client eent, and with all e equipme ice the ement will ar mealtin ity as well the QIDP n going ba t client #1	3-19-10 ent. 4-15-10 line as
l a	pproximately 11:00 a	.M. revealed that the day					

NT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA					
	IDENTIFICATION NUMBER:	A. BU		IPLE CONSTRUCTION	(X3) DATE S	
	89G072	B. Wi	NG_			
PROVIDER OR SUPPLIER	-		STE	REFT ADDRESS CITY STATE 710 CODE	03/1	9/2010
OF WASHINGTON			1.	318 45TH PLACE, NE		
: (EACH DEFICIENCY	MUST BE PRECEDED BY EIGH		ΙX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP	SINDE	(X5) COMPLETION DATE
Continued From pa	ge 3	W	120			
∍ staπ were not imple ∴ protocol.	menting Client #1's mealtime		120			
¹ 483.420(a)(2) PRO ¹ RIGHTS	FECTION OF CLIENTS	W 1	124			
parent (if the client is of the client's medic and behavioral state	/ must inform each client, s a minor), or legal guardian, al condition, developmental us, attendant risks of			an.		
review, facility failed would ensure clients informed of the risks programs and suppo	n, staff interview, and record to establish a system that and legal guardians were and benefits of restrictive rts, for one of the three			consent from family members guardians for sedations prior medical appointments. In reference to the sedation fo appointment on December 21 client #1's mother could not refacility due to the increment w	or legal to the r podiatry , 2010, port to the yeather, but	
The facility failed to prinformed consent wa	rovide evidence that s obtained from Client #2			The consent form was signed be in later days when the weather Client #2's mother signed the in	y the mother cleared ou nformed	t.
given during medical	d legal guardian for sedation appointments as evidenced			Refer to attachment #2	•	12-24-09
2010, beginning at 9: nurse (LPN), acting q professional (QMRP) (RM) indicated that th family" member to as:	00 a.m., licensed practical ualified mental retardation and residential manager e client had a "very involved sist the client in making			that informed consents are obtaining members or legal guardi	tained from ians, and the	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From paper program was inform staff were not imple protocol. 483.420(a)(2) PRORIGHTS The facility must ensist of the client's medical and behavioral state treatment, and of the state treatment, and of the state treatment of the risks programs and supportion of the sample. The facility failed to present in the sample. The facility failed to present in the sample. The facility failed to present was and/or court appointed given during medical below: During the entrance of 2010, beginning at 9:1010, beginning at 9:1010, indicated that the family member to asset to a server to a	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 program was informed "earlier in the year" that staff were not implementing Client #1's mealtime protocol. 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three clients in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or court appointed legal guardian for sedation given during medical appointments as evidenced	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 program was informed "earlier in the year" that staff were not implementing Client #1's mealtime protocol. 483.420(a)(2) PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three clients in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below: During the entrance conference on March 17, 2010, beginning at 9:00 a.m., licensed practical nurse (LPN), acting qualified mental retardation professional (QMRP) and residential manager (RM) indicated that the client had a "very Involved family" member to assist the client in making	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 program was informed "earlier in the year" that staff were not implementing Client #1's mealtime protocol. 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three clients in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below: During the entrance conference on March 17, 2010, beginning at 9:00 a.m., licensed practical nurse (LPN), acting qualified mental retardation professional (QMRP) and residental manager (RM) indicated that the client had a "very Involved family" member to assist the client in making	SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC ICENTIFYING INFORMATION) Continued From page 3 program was informed "earlier in the year" that staff were not implementing Client #1's mealtime protocol. 483, 420(a)(2) PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the three clients in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below: During the entrance conference on March 17, 2010, beginning at 9:00 a.m., licensed practical nurse (LPN), acting qualified mental retardation professional (QMRP) and residential manager (RM) indicated that the client had a "very invoked anily" member to assist the client in making mental to them.	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC ICENTIFYING INFORMATION) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) Continued From page 3 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) W 120 PREFIX TABLE PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) W 120 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY) W 121 W 122 PROTECTION OF CLIENTS W 124 It is the policy of RCM to obtain informed consent from family members, or legal guardians, or sedations prior to the medical appointments. It is the policy of RCM to obtain informed consent from family members, or legal guardians, or sedation from family members, or legal guardians for sedation from decine the sedation for professional (CIMPR) and residential manager (LPN), acting qualified mental retardation professional (QMRP) and residential manager (LPN), acting qualified mental retardation professional (QMRP) and residential manager (LPN), acting qualified mental retardation professional (QMRP) and residential manager (LPN), acting qualified mental retardation professional (QMRP) and residential manager (LPN), acting qualified mental retardation professional (QMRP) and resid

PRINTED: 04/08/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G072 03/19/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION OATE ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 124 Continued From page 4 W 124 It is the policy of RCM to obtain informed Review of Client #2's medical records on March consent from family members, or legal 18, 2010, at 12:20 p.m., revealed a telephone guardians for sedations prior to the order for Ativan 2 mg. 30 minutes prior to a medical appointments. December 21, 2009, podiatry appointment. In reference to the sedation for podiatry appointment on December 21, 2010, Review of Client #2's Psychological Assessment dated November 30, 2009, on March 18, 2010, at client #1's mother could not report to the 2:20 p.m., revealed that the client was not facility due to the increment weather, but competent to make decisions regarding his gave a verbal consent over the phone. health, safety, financial or residential placement. The consent form was signed by the mother Further review of the client's record failed to in later days when the weather cleared out. provide evidence that written informed consent Client #2's mother signed the informed had been obtained for the use of the sedatives. consent on 12-24-09 At the time of the survey, the facility failed to Refer to attachment # 2 provide evidence that the potential risks involved In the future, the nursing staff will ensure in using this medication, or his right to refuse that informed consents are obtained from treatment had been explained to the client and/or family members or legal guardians, and that family member. the risks involved with treatment are W 193 483.430(e)(3) STAFF TRAINING PROGRAM W 193 explained to them. Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to implement a client's behavior management plan, for one of three clients included in the sample. (Client #2)

The finding includes:

During medication observation on March 17, 2010, at approximately 7:10 a.m., Client #2 was observed vocalizing loudly, fidgeting, toying with his clothing and striking a desk several times.

DEPAI CENTI	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES				FORM): 04/08/2010 (APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		LTIPLE CONSTRUCTION	(X3) DATE :	
		09G072	B. WI	ING		004	10/0040
	PROVIDER OR SUPPLIER OF WASHINGTON			s	TREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019	<u> U3/1</u>	19/2010
(X4) ID PREFIX TAG	' (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT	ILD RE	(X5) COMPLETION DATE
W 193	During a face to face March 17, 2010, at a revealed Client #2 h targeted behaviors administration. Review of Client #2% dated on December 8:10 a.m., revealed aggression" and "fice	ical Nurse (LPN) made no he behaviors. e interview with the LPN on approximately 7:20 a.m., ad never exhibited any	W	19:	1	r Support ent	3-21-10
W 249	engages in physical react promptly and a redirection. The facility failed to e effectively trained specified behavior manageme	that stated if the client aggression be prepared to ppropriately and use verbal ensure nursing staff was ecifically on Client #2's	W 2	40	In the future, the facility management will ensure that all nurses work client #2 are trained on his Bel Support Plan.	ing with	
; ;	As soon as the interd formulated a client's i each client must rece treatment program co interventions and sen and frequency to sup	Isciplinary team has individual program plan, live a continuous active	***	70			
į	based on observation verification, the facility	not met as evidenced by: a, staff interview and record failed to ensure continuous ne of the three clients in the					į

DEPA CENT	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/08/2010 M APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE	O. 0938-0391 SURVEY PLETED
		09G072	B. WI	ING			
	PROVIDER OR SUPPLIER OF WASHINGTON			s	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019	03	/19/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT	UD RE	(X5) COMPLETION DATE
W 249	Continued From pa sample. (Client #2)	ge 6	w:	24			•
	Observations on Ma staff was heard aski	ed to implement Client #2's ividual Program Plan (IPP). Irch 17, 2010, at 4:05 p.m., ng, "[Client #2], where do you routing this evening." The					
	direct care staff was to the van. Upon the revealed that the clie	d. Several minutes later, the observed assisting the client eclient's return, the staff ent went to the local park.			All staff were trained on client # Communication goal. In addition, a new communicati		3-22-10
	2009, on March 18, program objective will improve his functional like/dislike system the	2010, 2:00 p.m., revealed a hich stated, "[the client] will all communication by showing rough tactile stimuli with and expansion to yes/no			assistive devise (Go talk one) was ordered on and delivered on Refer to attachment #4 (a) and		3-25-10 3-29-10
W 255	professional (QMRP) approximately 11:10 has an adaptive com device was revealed interview revealed this desired outing (i.e., p etc.) There was no evimplemented Client #	at the client should select a	W 25	55	In the future, the QIDP will ensi Client#2's communication goal i as written.		ented
; ; ;	professional and revis	m plan must be reviewed at mental retardation sed as necessary, including, utions in which the client has					

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/08/2010 APPROVED
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŀ	ULTIPLE CONSTRUCTION		(3) DATE SU COMPLE	
		09G072	B. Wil	IG			
NAME OF	PROVIDER OR SUPPLIER			CIDELL ADDRESS AND A		03/19	V2010
RCMC	F WASHINGTON			STREET ADDRESS, CITY, S 1318 45TH PLACE, NE WASHINGTON, DC			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	- ID		PLAN OF CORRECTIO		
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X (EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD CED TO THE APPROP EFICIENCY)	ORF I	(X5) COMPLETION DATE
W 255	Continued From page	ge 7	W	55			
		eted an objective or objectives	***				1
	review, the facility's Professional (QMRF that Individual Prograviewed and revised successfully complessed in the complex in the complex in the complessed in the complex in the complex in the complessed in the	ted an objective, for one of uded in the sample. (Client					
!	The QMRP failed to she met the establish	revise Client #3's IPP once ned criteria.					
	2010, at 7:20 a.m., the (LPN) was observed medications and spondications in apples observed retrieving the nurse and swallowing	on feeding the client her sauce. The client was then he cup of water from the the medications.		by the nurse and Refer to attachm In the future, the		ensure th	4-1-10 at
	administration, reveal participates in a self r	N, after the medication led that Client #3 nedication program. The get the cup of water from		progress. Client #3's media by the nurse and Refer to attachm		vas revise	d 4-1-10
;	2009, on March 10, 20 program objective wake the cup of water ner med with it on 20/	IPP dated September 11, 010, at 12:30 p.m., revealed hich stated, "[the client] will from the nurse and swallow 30 consecutive recorded data collection sheets from		In the future, the Client #3's progra	nurse/QIDP will		

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES				PRINTED	: 04/08/2010 I APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTI	IPLE CONSTRUCTION	OMB NO (X3) DATE S COMPL	
		09G072	8. W	NG_			
	PROMDER OR SUPPLIER PF WASHINGTON		 .	1	REET ADDRESS, CITY, STATE, ZIP CODE 318 45TH PLACE, NE VASHINGTON, DC 20019	<u> </u>	9/2010
(X4) ID PREFIX TAG	* (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	ΊΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	Din AE	(X5) COMPLETION DATE
W 255	Continued From pa August 2009, throug that the client was in recorded.	ge 8 gh February 2010, revealed ndependent on all trials	W:	255	DEFICIENCY)		
W 261	- -	RAM MONITORING &	W	261			
	of members of facility guardians, clients (a persons who have e contemporary practic	signate and use a specially se or committees consisting by staff, parents, legal s appropriate), qualified ither experience or training in ces to change inappropriate persons with no ownership or the facility.					
	Rights Committee (Hailed to ensure that controlling interest in participated on the co	not met as evidenced by: and review of the Human IRC) minutes, the facility persons with no ownership or the facility consistently committee, for one of the in the sample. (Client #2)			It is the policy of RCM to have C Representatives, as members of	•	
:	2010, beginning at 9: mental retarded profe practical nurse (LPN) (RM) Indicated that C prior to an EEG appoi	conference on March 17, 00 a.m., the acting qualified essional (QMRP), licensed and the residential manager lient #2 required sedation intment. It was further 2 had a very involved family ling to sign medical			however, on February 19, 2009 advocate did attend the meetir happened to be one of RCM's is mother. Refer to attachment #6. Many efforts have been made to that review of the facility's HRC persons with no ownership or cointerest in the facility. This is an process.	ng, and ndividual's o ensure include ontrolling ongoing	
	16, 2010, at 12:20 p.n	physician orders on March n., verified that sedation ered to be administered			Refer to attachment #6 (current Sheets).	: HRC signa	iture

CENT	ERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/08/2010 APPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IULTIPLE CONSTRUC	TION	(X3) DATE S	
		0 9 G072	B. WI	v G		1	
	PROVIDER OR SUPPLIER OF WASHINGTON			STREET ADDRESS, 1318 45TH PLAC WASHINGTON		03/1	<u>9/2010</u>
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROV X (EACH C	MDER'S PLAN OF CORRECTOR SHOEFERENCED TO THE APPROPRIES OF THE APP	III D RE	(X5) COMPLETION DATE
	Review of the Huma meeting minutes wa 2010, at 3:30 p.m. Adated February 1, 20 an EEG laboratory s February 19, 2009, v Further review of the sheet attached to the that the facility's HRC persons with no own in the facility. This was interview with the QN approximately 10:00 483.460(g)(2) COMP TREATMENT	oratory study was scheduled 10. In Rights Committee (HRC) is conducted on March 18, According to the HRC minutes 1009, Client #2's sedation for study was scheduled for the was reviewed and approved. It is committee included ership or controlling interest as acknowledged through MRP, March 19, 2010, at a.m. PREHENSIVE DENTAL	W:	It is the policy is the policy interest in process. Representation in the policy interest in process. Refer to attraction in process. Refer to attraction process. Refer to attraction process.	licy of RCM to have of atives, as members of on February 19, 2009 did attend the meeti to be one of RCM's tachment #6 rts have been made to v of the facility's HRC th no ownership or of the facility. This is an tachment #6 (curren	of the HRC; 9, only one ng, and individual's to ensure Cinclude controlling	
į	reatment services the needed for relief of parestoration of teeth, a health. This STANDARD is a Based on interview are failed to ensure timely treatment services for health, for one of the sample. (Client #3) The finding includes: Review of Client #3's and 19, 2010, beginning as	at include dental care ain and infections, and maintenance of dental not met as evidenced by: and record review, the facility of comprehensive dental three clients included in the at 9:30 a.m., revealed a am dated September 8		to verify th by Medicai Scheduled See attache In the futur the individu	Is were made to the e status of the scalind; the follow-up app for ed consultation formet, the facility will enuals are provided witon a timely manner.	ng approval ointment is sure that	4-27-10

DEPAI CENTI	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES				PRINTE FOR	D: 04/08/2010 M APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I		LTIPLE CONSTRUCTION DING	OMB N (X3) DATE	<u>O. 0938-0391</u>
		09G072	B. WI	ING			
	PROVIDER OR SUPPLIER OF WASHINGTON			s	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019	03.	/19/2010
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	FIX	PROVIDER'S PLAN OF CORRECT	III D RE	(X5) COMPLETION DATE
	dental consultation of 2009. The consultation of 2009. The consultation of 2009. The consultation heavy calculus descaling on the next valicensed practical nut 2010, at approximate the client needed prefereturning to the dent time of the survey, the Client #3 received time (scaling). 483.470(g)(2) SPAC The facility must furn and teach clients to use the consultation of the use the consultation of the	calculus deposits and needed iew revealed an additional form dated November 18, tion form revealed moderate eposits and recommended visit. Interview with the larse (LPN) on March 19, ely 10:00 a.m., revealed that eauthorization prior to eauthorization prior to est office for scaling. At the ne facility failed to ensure nely dental services E AND EQUIPMENT ish, maintain in good repair, use and to make informed e of dentures, eyeglasses, mmunications aids, braces, entified by the las needed by the client.	W:		Several call s were made to the to verify the status of the scaling by Medicaid; the follow-up apposite Scheduled for See attached consultation form. In the future, the facility will entitle individuals are provided wit treatment on a timely manner.	g approva pintment i sure that	s 4-27-10
1	review, the facility fail clients wheelchair and	not met as evidenced by: n, interview, and record ed to maintain in good repair d shower chair for safety, for nts included in the sample.	·	į			
	The findings include:				The vendor was contacted by th LPN, and 719-A form was submit Client #3's wheelchair will be as:	tted on	3-25-10 4-19-10
	 The facility falled to Client #3's wheelchair 	o maintain in good repair			Refer to attachment # 7 In the future, the facility will ens		7 13 10
•	On March 17, 2010, a observed in a wheelch missing. Interview wit	t 7:50 a.m., Client #3 was lair. The left anti-tipper was th the direct care staff			all of the individuals' durable mequipment are always in good re	edical	lition.

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	09G072				
PROVIDER DR SUPPLIER		./		03/19/2010	
F WASHINGTON			1318 45TH PLACE, NE	DDE .	
(LAUN DEFICIENC)	Y MUST BE PRECEDED BY CHIL	(D PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLETION	
Continued From pa	ge 11	14/4			
anti-tipper. Intervie nurse (LPN) on Mal 8:30 a.m., indicated Although the wheel facility within the particular client #3's wheelch.	w with the license practical rch 17, 2010, at approximately I that he was also not aware. chair distributor was all the st two weeks, making repair to air.		LPN, and 719-A form was s Client #3's wheelchair will I Refer to attachment # 7 In the future, the facility wi all of the individuals' durab	submitted on 3-25-10 be assessed 4-19-10 Ill ensure that le medical	
snower chair was sathe six five clients re #1, #3, and #4) On March 17, 2010, #3 were observed in was observed using environmental inspectoserved in the bath chair's seatbelt did not be seatbelt in place. The teardation (QMRP) as environmental inspectication in the properties of the properties.	at 8:00 a.m., Clients #1, and wheelchairs and Client #4 a roller walker. During the ction on March 19, 2010, at m., a shower chair was room shower. The shower of have a latch to hook the le acting qualified mental and LPN, during the ction confirmed that the The LPN indicated that he		LPN to assess the bathroor The shower chair will be as 719-A was submitted for th of the old chair by a new or Refer to attachment #7 In the future, the facility may will ensure that all of the i	n shower chair. ssessed on 4-19-10 e replacement ne. anagement ndividuals'	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From parevealed that they wanti-tipper. Intervienurse (LPN) on Mar 8:30 a.m., indicated Although the wheeler facility within the paracellity within the paracellity within the paracellity within the relevance of the relevance of the relevance of the relevance of the six five clients relative. 2. The facility failed shower chair was satisfive clients relative. 2. The facility failed shower chair was satisfive clients relative. 3. The facility failed shower chair was satisfive clients relative. 4. When the satisfied in the bath chair's seatbelt did not be a seatbelt in place. The transportation (QMRP) are relative to the satisfied of the seatbelt was broken.	PROVIDER DR SUPPLIER F WASHINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 revealed that they were not aware of the missing anti-tipper. Interview with the license practical nurse (LPN) on March 17, 2010, at approximately 8:30 a.m., indicated that he was also not aware. Although the wheelchair distributor was all the facility within the past two weeks, making repair to Client #3's wheelchair. There was no evidence that the wheelchair was assessed for the replacement of the safety feature. 2. The facility failed to ensure that the adaptive shower chair was safe for clients use, for three of the six five clients residing in the facility. (Clients	PROVIDER DR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 revealed that they were not aware of the missing anti-tipper. Interview with the license practical nurse (LPN) on March 17, 2010, at approximately 8:30 a.m., indicated that he was also not aware. Although the wheelchair distributor was all the facility within the past two weeks, making repair to Client #3's wheelchair. There was no evidence that the wheelchair was assessed for the replacement of the safety feature. 2. The facility failed to ensure that the adaptive shower chair was safe for clients use, for three of the six five clients residing in the facility. (Clients #1, #3, and #4) On March 17, 2010, at 8:00 a.m., Clients #1, and #3 were observed in wheelchairs and Client #4 was observed using a roller walker. During the environmental inspection on March 19, 2010, at peginning at 3:26 p.m., a shower chair was observed in the bathroom shower. The shower chair's seatbelt did not have a latch to hook the seatbelt in place. The acting qualified mental etardation (QMRP) and LPN, during the environmental inspection confirmed that the eatbelt was broken. The LPN indicated that he eatbelt was broken. The LPN indicated that he	PROVIDER DR SUPPLIER F WASHINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 revealed that they were not aware of the missing anti-tipper. Interview with the license practical nurse (LPN) on March 17, 2010, at approximately 8:30 a.m., indicated that the was also not aware. Although the wheelchair distributor was at the facility within the past two weeks, making repair to Client #3's wheelchair. There was no evidence that the wheelchair was assessed for the replacement of the safety feature. 2. The facility failed to ensure that the adaptive shower chair was safe for clients use, for three of the six five clients residing in the facility. (Clients #1, #3, and #4) On March 17, 2010, at 8:00 a.m., Clients #1, and KS were observed in wheelchairs and Client #4 was observed using a roller walker. During the anvironmental inspection on March 19, 2010, at beginning at 3:26 p.m., a shower chair was observed in the bathroom shower. The shower hair's seatbelt did not have a latch to hook the seatbelt in place. The acting qualified mental elardation (QMRP) and LPN, during the eartbelt was broken. The LPN indicated that he eatbelt was broken. The LPN in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER	HFD03-0173	B. WING		03/1	9/2010	
R C M OF WASHINGTON	1318	T ADDRESS, CITY, 45TH PLACE, N HINGTON, DC 2	F		<i>3</i> 42010	
TAG REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTINUES INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPL DATE	
was initiated using the process. A random was selected from a and two male resider mental retardation and two male resider mental retardation and the findings of the subservations at the group of the subservations at the group of the contract and administration incident reports. R 125 4701.5 BACKGROUN The criminal backgroup criminal history of the contract worker for the in all jurisdictions within employee or contract worker for the in all jurisdictions within the seven check. This Statute is not me based on the review of GHMRP ensured criminal jurisdictions in which worked or resided within the seven check.	ras conducted from March arch 19, 2010. The survey be fundamental survey sample of three residents population of four female atts with various levels of ad disabilities. Invey was based on roup home and two day with staff, and the review of attive records including. ID CHECK REQUIREMENT and check shall disclose the prospective employee or a previous seven (7) years, in which the prospective worker has worked or an (7) years prior to the asseving presented by: It as evidenced by: It a	T R 125	DEFICIENC	7)		

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0173 03/19/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DATE DEFICIENCY) R 125 Continued From page 1 R 125 however, that a background check had been Staff # 6's background check record is obtained for that jurisdiction prior to her 4-10-10 currently on file. employment. In the future, the provider will ensure that all personnel background records are on file, and provided upon request. Refer to attachment #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM HFD03-0173	KCLIA (X2) MI BER: A. BUIL B. WIN		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CIT		03/19/2010
R C M OF WASHINGTON		1318 457H PLACE WASHINGTON, DO	. NE	
PREFIX PACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F IC IDENTIFYING INFORMATI	10	PROVIDER'S PLAN OF C	ON SHOULD BE COMPLE RE APPROPRIATE DATE
was initiated using the process. A random was selected from a and two male resider mental retardation are the findings of the subservations at the gorograms, interviews clinical and administration incident reports. 1090 3504.1 HOUSEKEEP The interior and exter maintained in a safe, and sanitary manner accumulations of dirt, odors. This Statute is not me Based on observation	vas conducted from March 19, 2010. The sure fundamental survey sample of three reside population of four fennts with various levels and disabilities. urvey was based on aroup home and two downth staff, and the revalve records including the properties of the clean, orderly, attractional be free of the county to the county to the county the	ents hale of ay view of g I 090 hall be ive, hable		
interior of the GHMRP orderly, attractive, and six residents residing i #1, #2, #3, #4, #5 and	HMRP) failed to ensul was maintained in a I sanitary manner, for in the facility. (Reside	re the clean, six of		
An environmental inspi 19, 2010, beginning at following: 1. The gutter on right to observed pulled from the	3:26 p.m. revealed the	e .	The gutter was repaired on In the future, the facility wi facility gutters are in a good	ill ensure that the

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
3414E 0E		HFD03-0173		B. WING 03/19/20				
NAME OF	PROVIDER DR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE				
RCMC	OF WASHINGTON	,	WASHING	TH PLACE, GTON, DC	NE 20019	•		
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	;	į (D	PROVIDER'S PLAN OF CORRECT			
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL TION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
1 090	90 Continued From page 1			1 090				
	nolder was broken.		ead		The handicapped bathroom shower head was replaced on 3. In the future, the facility management will ensure that all of the adaptive equipment are in a good repair condition.			
1 095	3504.6 HOUSEKEE			l 09 5				
	Each poison and ca a locked cabinet and of each resident.	austic agent shall be st d shall be out of direct	tored in t reach					
	Hased on observation Home for Mentally Refailed to store poisor locked cabinet and/or resident, for six of the	met as evidenced by: on and interview, the G Retarded Persons (GH ns and caustic agents or out of direct reach o ne six residents residin #1, #2, #3, #4, #5 and	IMRP) in a of each			į		
	The finding includes:	•						
	all purpose cleaner, I cleaners) were obserundemeath the residents were obserundents were obserundents were obserundents. The unsection walk-thru. The unsection walk-thru.	rved to use the bathrood the environmental cured caustic agents wo buse manager on the s	nts (i.e.,		All staff were trained on chapter 3 emphasis on the securing of the cagents. Refer to attachment #8 In the future, the facility manager ensure that all of the caustic agen in a locked cabinet.	austic 3-22-10 ment will		
1 203	3509.3 PERSONNEL	. POLICIES		1 203				
· (descriptions with each	I discuss the contents h employee at the beg east annually thereafte	innina					
; 7	This Statute is not me	et as evidenced by:						

<u>Health</u>	Regulation Administra	ation				FORM /	APPROVED
STATEME! AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	:R/CLIA MBER:	(X2) MU A. BUILL B. WING		(X3) DATE SU COMPLE	
NAME OF	PROVIDER OR SUPPLIER	111 100-0110	OTDEET A	222500 OF		03/19	9/2010
				DURESS, CIT TH PLACE,	Y, STATE, ZIP CODE	 _	
R C M C	OF WASHINGTON		WASHIN	IT PLACE, IGTON, DC	NE 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	EHILL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II A RE	(X5) COMPLETE DATE
l 20 3	Continued From page	ige 2		i 203			
	(GHMRP), failed to current job description out of eleven staff.	•	8 W				
	professional (QMRP personnel files cond beginning at 2:45 p.r failed to provide evid discussed the conterstaff. It should be no	s: ualified mental retards) and review of the G ducted on March 19, 2 m., revealed the GHN dence that the facility ents of job descriptions oted that the presente ide a job descriptions	SHMRP's 2010, VIRP s with all		It is RCM policy that all staff have descriptions on file. Currently staff #2 and 6's job desc are on file. Refer to attachment #9 In the future, the personnel deparensure that that all staff jobs desc are on file, and available upon req	criptions rtment will criptions	3-22-10
1 206	3509.6 PERSONNE	L POLICIES		1 206			
	Each employee, prior annually thereafter, s certification that a her performed and that the would allow him or he duties.	shall provide a physici ealth inventory has be the employee 's healt	ian's en th status				
	This Statute is not me Based on interview ar Home for the Mentally (GHMRP), failed to er consultant had a curre qualified mental retard three of the thirteen st consultants.	and record review, the ly Retarded Persons ensure each staff and rent health certificate, relation professional (C	for the				

H e alth	Regulation Administra	ation				FORM A	APPROVED
STATEMEI AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0173		R/CLIA MBER:	(X2) MU A. BUILE B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	1 000-0110	STREET AT	DDESS CM	Y, STATE, ZIP CODE	03/19	3/2010
RCMO	F WASHINGTON		1318 45T WASHING	TH PLACE, GTON, DC	NF		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	ELIL I	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IID RE	(X5) COMPLETE DATE
1 206	Continued From pa	ge 3	····	1206		<u> </u>	
l 227	personnel records of at 2:45 p.m., reveals provide evidence the were on file for the (•	eginning to ficates	1 227	RCM policy that all staff have curred Health certificates on file. Currently the QIDP and staff #4, 9 Health certificates are current and Refer to attachment # 11 In the future, the personnel deparensure that that all staff records a	5, and 7's d on file. rtment will	
: : :	Each training progra limited to, the followi	m shall include, but r	ot be	1227	and available upon request.	ine current,	
	(d) Emergency proce cardiopulmonary res Heimlich maneuver, evacuation plans;	uscitation (OPR) the	. 1				
<u> </u>	This Statute is not m Based on record revi Mentally Retarded Pe have on file for review cardiopulmonary resi the eleven staff and of five of the eleven staff	ew, the Group Home ersons (GHMRP) faile w current training in uscitation (CPR), for current training in first	ed to		RCM policy that all staff be trained and first aid. Attachment #11 In the future, the personnel departensure that that all staff records a and available upon request.	tment will	4-1-10
	The finding includes:		!				
	Review of the person March 19, 2010, beging the GHMRP failed to staff training in CPR, and current training in eleven staff.	nning at 2:45 p.m., re provide documentations for three of the eleve	evealed on of n staff				
1229	3510.5(f) STAFF TRA	LINING		l 229			

_ Health	Regulation Administra	ation				FORM A	APPROVED
STATEME AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER 1993-0173	R/CLIA VIBER:	(X2) MUS A. BUILD B. WING	ING	X3) DATE SU COMPLE	
NAME OF	PROVIDER OR SUPPLIER	1 HFD03-01/3	027777	L		03/19	/2010
ļ					, STATE, ZIP CODE		
R C M OF WASHINGTON 1318 45 WASHIN		WASHING	H PLACE, STON, DC	NE 20019			
(X4) ID PREFIX TAG	REGULATORY DR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	C) () (ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	n RF	(X5) COMPLETE DATE
1 229	Continued From page	ge 4		l 229			
	imited to, the follow	•					
	 residents to be serve to, behavior manage 	elated to the GHMRP ed including, but not le ement, sexuality, nutri nmunications, and ass	imited ition				
	This Statute is not in Based on observation review, revealed the to demonstrate complementation of the (BSP), for one of thresample. (Resident #2) The finding includes: During medication of 2010, at approximate was observed to serve the same of	on, interview and reco facility's nursing staff petency in the e Behavior Support P ee residents included 2) Deservation on March 1	failed land in the		All nurses were inserviced by the Ir Management Coordinator who was Acting QIDP on client #2's Behavior Plan Refer to attachment #3 In the future, the facility will ensure nurses are trained on client #2's Be Support Plan.	s the r Supp or t e that all	3-21-10
<u>.</u>	was observed vocalize with his clothing and stimes. The licensed property of times. The licensed property of the licensed property of the licensed property of the licensed provided the license provi	striking a desk severa practical nurse (LPN) the behaviors. interview with the LP oproximately 7:20 a.m had never exhibited for to medication 2's behavior support; mber 13, 2010, at m., revealed Residen estion" and "fidgeting" as two of his targeted	made N on n., any olan t #2's		All nurses were inserviced by the In Management Coordinator who was Acting QIDP on client #2's Behavior Plan Refer to attachment #3 In the future, the facility will ensure nurses are trained on client #2's Be Support Plan.	s the Support	3-21-10
ا ب	that stated if the residence aggression be prepare	ent engages in physic	أاع				ĺ

Health	Regulation Administra	ation				FORM APPROVED
STATEMI AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	:R/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	HFD03-0173	ETDEET AL			03/19/2010
		1			Y, STATE, ZIP CODE	,
RUM	OF WASHINGTON		WASHING	TH PLACE, IGTON, DC	NE 20019	
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	CHIL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED FICIENCY)	DIBDRE COMMETE
l 229	9 Continued From pa	ige 5	<u> </u>	1229		
		se verbal redirection.		. — -		
	The facility failed to effectively trained spendomenagement	ensure nursing staff pecifically on Resider ent plan.	was nt #2's			
l 29	1, 3514.2 RESIDENT	RECORDS	ĺ	1 291		
	Each record shall be signed by each indiv	e kept current, dated, vidual who makes an	and entry.			
	Home for the Mental (GHMRP), failed to	met as evidenced by: and record review, the illy Retarded Persons ensure entries in each for one of the three n ident #1)	e Group			
	The finding include:					
; ;	On March 17, 2010, interview with the lice revealed that Resider the facility in October months ago). On Mareview of Resident # revealed a functional assessment was dat signed by the person	ensed practical nurse ent #1 had been admit r 2009 (approximately arch 18, 2010, at 11:2 l's habilitation record I assessment. The ted October 12, 2009 completing the asses	itted to y six 23 a.m., I but not ssment.		The functional assessment was The QIDP who left the Provider i however, the acting QIDP did ref Functional assessment, and sign Refer to attachment # 12 In the future, the facility manage that all of the assessments are of signed upon completion.	in December 2009; view the ed off on it. 3-22-10 ement will ensure
I 405	3520.7 PROFESSION PROVISIONS	N SERVICES: GENE	:RAL	1 405		
	Professional services programs operated by employed by the GHM between the GHMRP including both public a individual practitioners	y the GHMRP or pers MRP or by arrangeme and other service pro and private agencies	sonnel ents			

I 405 Continued From page 6	
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 26619 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1 405 CONTINUED FROM DEFICIENCY PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ט
R C M OF WASHINGTON 1318 45TH PLACE, NE WASHINGTON, DC 20019 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1 405: Continued From page 6 1 405	2010
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) I 405 Continued From page 6 WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1 405 Continued From page 6 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	(X5) COMPLETE DATE
Resident #1's spoon and handing it to the resident. The resident was observed putting the food into her mouth, after verbal cueing. The resident used a right handled curved spoon, high	-19-10 I-15-10

<u>Health</u>	Regulation Administr	ration				FORM A	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		DING	3) DATE SUI COMPLET		
NAME OF	PROVIDER OR SUPPLIER	1	STREET AL	DODESS OF	Y, STATE, ZIP CODE	03/19/	/2010
	F WASHINGTON	_	1318 457	TH PLACE, GTON, DC	NE		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	E 11 11 1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	06	(X5) COMPLETE DATE
# A STATE OF THE S	approximately 5:17 #1's nutritional asse 2009, recommende spoon, high sided pi Additional record reitime revealed Resid dated January 2, 20 "nosey cup" be used the meal. The asse an independent feed Staff should set the encourage her to ea hand and verbally cu Interview with the qu professional (QMRP approximately 11:00 completed day prograyear. During those of indicated that the day implementing Reside Interview with the lice March 19, 2010, at a revealed that he sent assessment to the da 2010. Record verifica approximately 1:30 p. from the day program Resident #1's nutrition guidelines. I. The facility failed to with Resident #1 at he appropriate level of as unch observations we also day program on the complexication of the complexication of the proportiate level of as unch observations we also day program on the	p.m., revealed that Ressment dated Octobed a right handled cumplate, and dycem mat. Eview on the same dated that #1's nutritional quality of the minimize spillage essment further stated der with staff supervisions and in front of the heat by putting the spoorule her to eat. Italified mental retardary on March 19, 2010, a.m., revealed that he ram observations, the QMI by program staff were ent #1's mealtime program staff were ent #1's mealtime program nurse in Justion on March 19, 20, m., revealed document acopy of the nutritional program nurse in Justion on March 19, 20, m., revealed document acopy of the nutritional program nurse that they received a seessment and for the day program provides a sees and assessment and for ensure that staff were day program provides sistance during her refere observed at Resil March 17, 2010, at 12	per 12, oved lite and liter and liter and liter this like had not liter this like had not liter and liter this like had not liter and	1405	The facility nurse reported to client # program, and inserviced the staff on #1's mealtime adaptive equipment, mealtime protocol. The day program was provided with of client #1,s mealtime adaptive equipment facility nurse went to inservice the day program staff again on Refer to attachment #1. In the future, the facility management ensure that client #1 uses similar meadaptive equipment at the facility as at the day program; in addition, the is visiting the day program on an goind during lunch time to ensure that client is provided with the appropriate meadaptive equipment	n client and all uipment. he nt will realtime s well as QIDP ing basis ent #1	3-19-10 4-15-10
· p.	en's day program on to the day program seding the resident, u	m staff was observed	ı J				

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER** COMPLETED A. BUILDING B. WING HFD03-0173 03/19/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 (X4) ID | PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1405 Continued From page 8 1405 techniques. An elevated plate riser, a regular plate, a built up handle spoon and a styrofoam cup were used during the meal. The plate was observed sliding on the elevated plate riser. The facility nurse reported to client #1's day program, and inserviced the staff on client Interview with the day program staff on March 17, 2010, at approximately 1:20 p.m., revealed that #1's mealtime adaptive equipment, and Resident #1 required hand over hand assistance mealtime protocol. 3-19-10 to eat her meals. The day program was provided with all of client #1,s mealtime adaptive equipment. Record review on March 17, 2010, at The facility nurse went to inservice the approximately 5:17 p.m., revealed Resident #1's day program staff again on nutritional assessment dated October 12, 2009, 4-15-10 indicated that the resident was an independent "feeder" with staff supervision. The staff should Refer to attachment #1. set the meal in front of the [the resident] and encourage [the resident] to eat, by putting the In the future, the facility management will spoon in her hand and verbally cueing [the ensure that client #1 uses similar mealtime resident) to eat. adaptive equipment at the facility as well as interview with the QMRP on March 19, 2010, at at the day program; in addition, the QIDP approximately 11:00 a.m., revealed that the day is visiting the day program on an going basis program was informed "earlier in the year" that during lunch time to ensure that client #1 staff were not implementing Resident #1's is provided with the appropriate mealtime mealtime protocol. adaptive equipment.. 1 422 3521.3 HABILITATION AND TRAINING 1422 Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the three residents included in the sample. (Resident #2)

neam	<u>Regulation Administr</u>	<u>ation</u>	•			LOKWI APPROVED
STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENT/FICATION NUM HFD03-0173	VCLIA IBER:	(X2) MUI A. BUILD B. WING		(X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER		STREET AG	DBESS OF	07176 700	03/19/2010
					, STATE, ZIP CODE	- ···
	F WASHINGTON		WASHING	H PLACE, STON, DC	NE 20019	
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SCIDENTIFYING INFORMAT	114.1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE COMPLETE
1422	22 Continued From page 9			l 422		
!	The finding includes The facility staff fail	s: ed to implement Resid	lent #2's			
	Observations on Ma staff was heard ask you wanted to go or The resident did not later, the direct care the resident to the vi-	ividual Program Plan (arch 17, 2010, at 4:05 ing, "[Resident #2], who your outing this even respond. Several min staff was observed as an. Upon the resident aled that the resident	p.m., pere do ing." nutes ssisting		The functional assessment was The QIDP who left the provider however, the acting QIDP did refunctional assessment, and sign Refer to attachment # 12 In the future, the facility manage that all of the assessments are signed upon completion.	in December 2009; eview the ned off on it. 3-22-10 gement will ensure
	2009, on March 18, program objective we will improve his functions showing like/dislike swith eventual developes/no system. Interview with the quaprofessional (QMRP) approximately 11:10 Resident #2 has an adevice. The device we further interview reveshould select the design of the	#2's IPP dated Deceme 2010, 2:00 p.m., reveal thich stated, "[the residual communication by the system through tactile present and expansion alified mental retardation March 19, 2010, a.m., indicated that the daptive communication was revealed at that tirealed that the resident ired outings (i.e., park). There was no evidented Resident #2's	aled a lent] by stimuli to ion at e on		The functional assessment was The QIDP who left the provider however, the acting QIDP did refunctional assessment, and sign Refer to attachment #8 In the future, the facility manage that all of the assessments are esigned upon completion,	in December 2009; eview the ned off on it. 3-22-10 gement will ensure
, , E : n	ach GHMRP shall m	TON AND TRAINING take modifications to to the teast every six (6) m	he	424		

Health !	Regulation Administra	ation				FORM	APPROVED
STATEMEN AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENT/FICATION NUM	ICATION NUMBER: A. BUILDING B. MARING		ING	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	HFD03-0173				03/	19/2010
					, STATE, ZIP CODE		
RCMO	OF WASHINGTON		WASHIN	TH PLACE, A GTON, DC	NE 20019		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	:111 1	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIECT)	DULD BE	(X5) COMPLETE DATE
	Continued From pa	=		1 424			
;	(a) Has successfully objectives identified Plan;	ly completed an object if in the Individual Habi	ive or ilitation				
	Group Home for the (GHMRP's) Qualified Professional (QMRF) the Individual Programs resident had succes	met as evidenced by: rviews and record revie Mentally Retarded Peter Mentally Retardation P) failed to review and am Plan (IPP) once the safully completed an oten for two of the three residents #2 and #3)	ersons I revise ne biective				
į	The finding includes	r.					
:	1. The QMRP failed once he met the esta	to revise Resident #2 ablished criteria.	?'s IPP				
:	staπ was observed p assistance to Reside hands. Interview with	10, at 3:50 p.m., direct providing hand over ha ent #2 with washing his th the staff on the same 5 p.m., indicated that h	and s ne day				
	was reviewed on Mar The resident had a prostated, "[the resident] and after meals with a from staff on 80% of consecutive months". QMRP monthly notes 2009, through Februa	ated December 13, 200 perch 18, 2010, at 2:10 perogram objective which will wash his hands be hand over hand assist the trials per month for a Record verification of dated from September 2010, indicated that e established criteria si	p.m. ch cefore tance or three of the er		Client #2's hand washing progra is being revised, and the change indicates the progress made. Criteria revised to 75% physical Refer to attachment #13. In the future, the QIDP will ensu are revised once the individual r	e in criteria I assistance ure that the	e 3-30-10 e goals
A	At the time of the sun evise Resident #2's	vey, the QMRP failed t program objective once	to e he				

Health	Regulation Administra	ation				FORM	APPROVED
STATEME AND PLAI	FATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ER/CLIA MBER:	(X2) MUI A. BUILD B. WING		(X3) DATÉ SURVEY COMPLÉTED	
NAME OF	PROVIDER OR SUPPLIER	HFD03-0173				03/1	9/2010
					, STATE, ZIP CODE		
RCM	OF WASHINGTON		WASHIN	TH PLACE, GTON, DC	NE 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FIRE	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UID BE	(X5) COMPLETE DATE
424	Continued From pa	ge 11		1424		-	;
	met the established	criteria.					
	There was no evide the program (hand)	nce that the QMRP r washing).	evised				
	2. The QMRP failed to revise Resident #3's IPP once she met the established criteria. During medication observations on March 18, 2010, at 7:20 a.m., the licensed practical nurse (LPN) was observed preparing Resident #3's medications and spoon feeding the client her medications in applesauce. The resident was then observed retrieving the cup of water from the nurse and swallowing the medications.			Client #3's medication skills IPP by the nurse and QIDP on	was revised 4-1-10		
				Refer to attachment # 5 In the future, the nurse/QIDP will ensure that the individuals' program goals are revised as they make progress.			
;	Interview with the LP administration, revea participate in a self nresident was required the nurse.	lled that Resident #3	The				
	Review of Resident: 11, 2009, on March 1 revealed a program or resident] will take the and swallow her med recorded trials." Rev sheets from August 2 2010, revealed that the on all trials recorded.	10, 2010, at 12:30 p.robjective which stated cup of water from the with it on 20/30 consiew of the data collection, through Februate resident was index	m., d, "[the le nurse secutive ction		Client #3's medication skills IPP by the nurse and QIDP on Refer to attachment #5 In the future, the nurse/QIDP will the individuals' program goals ar make progress.	Il ensure th	4-1-10 at
l 500	3523.1 RESIDENT'S	RIGHTS		1 500			
:	Each GHMRP resider that the rights of resid protected in accordanchapter, and other applays.	lents are observed ar ice with D.C. Law 2-1	nd 137 this				<i>x</i>

Health I	Regulation Administra	ation			FOR	M APPROVED
STATEMEN AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	CATION NUMBER: A. BUILDING		DINGCOMP	SURVEY
NAME OF (PRDVIDER OR SUPPLIER	HFD03-0173			03/	/19/2010
1					Y, STATE, ZIP CODE	
	F WASHINGTON		WASHING	'H PLACE, GTON, DC	NE 20019	
(X4) ID PREFIX TAG	REGULATORY OR LE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Filti	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page	ge 12		1 500		
:	Retardated Persons and protect resident Title 7, Chapter 13 called D.C. Law 2-1; Chapter 19) and other that govern the care mental retardation, for the facility. (Resident Persons and protect resident The finding includes:	provide evidence that as obtained from Clie ed legal quardian for	ecord itally bbserve ce with merly 6, al laws is with esidents			
; (During the entrance (2010, beginning at 9: nurse (LPN), acting a professional (QMRP) (RM) indicated that the family member to asshealth care decisions	:00 a.m., licensed pra qualified mental retard) and residential man- he client had very invo- sist the client in makil s.	actical dation lager olved ng		It is the policy of RCM to have Community Representatives, as members of the HRC; however, on February 19, 2009, only one advocate did attend the meeting, and happened to be one of RCM's individual's mother. Refer to attachment #6	
C	Review of Client #2's 18, 2010, at 12:20 p.r order for Ativan 2 mg, appointment dated De	m., revealed a teleph J, 30 minutes prior to J ecember 21, 2009.	one podiatry		Many efforts have been made to ensure that review of the facility's HRC include persons with no ownership or controlling interest in the facility. This is an ongoing	
. 0 2 0 1 h	Review of Client #2's dated November 30, 22:20 p.m., revealed the competent to make denealth, safety, financial further review of the competent and the comp	2009, on March 18, 2 nat the client was not ecisions regarding his all or residential place	2010, at		process. Refer to attachment #6 (current HRC signa Sheets).	3-22-10 iture

PRINTED: 04/08/2010 FORM APPROVED (X3) DATE SURVEY COMPLETED 03/19/2010 COMPLETE DATE DEFICIENCY) 3-22-10

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-0173 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **ID** PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG 1500 Continued From page 13 1500 provide evidence that written informed consent had been obtained for the use of the sedative It is the policy of RCM to have Community medication. Representatives, as members of the HRC; however, on February 19, 2009, only one At the time of the survey, the facility failed to advocate did attend the meeting, and provide evidence that the potential risks involved happened to be one of RCM's individual's in using this medication, or his right to refuse treatment had been explained to the client and/or mother. Refer to attachment #6. family member representative. Many efforts have been made to ensure that review of the facility's HRC include persons with no ownership or controlling interest in the facility. This is an ongoing Refer to attachment #6 (current HRC signature Sheets).